Office - Supreme Court
FILED
JAN 4 1982
ALEXANDER L. STEVAS,
CLERK

No. 80-1417

OCTOBER TERM, 1980

SUPREME COURT OF THE UNITED STATES

MARK J. MILLS, MICHAEL GILL AND
WILLIAM MALAMUD,
Petitioners

v.

RUBIE ROGERS, ABLE BOLDEN, BETTY BYBEL,
JAMES COLLERAN, DONNA HUNT,
WILLIE WADSWORTH AND HAROLD WARNER,
Respondents,

ON WRIT OF CERTIORARI TO
THE UNITED STATES COURT
OF APPEALS FOR THE FIRST CIRCUIT

PETITIONERS' REPLY BRIEF

Stephen Schultz, Esq.
Massachusetts Department of
the Attorney General
One Ashburton Place
Boston, MA 02108
Tel.: (617) 727-4538

No. 80-1417

OCTOBER TERM, 1980

SUPREME COURT OF THE UNITED STATES

MARK J. MILLS, MICHAEL GILL AND
WILLIAM MALAMUD,
Petitioners

v.

RUBIE ROGERS, ABLE BOLDEN, BETTY BYBEL,
JAMES COLLERAN, DONNA HUNT,
WILLIE WADSWORTH AND HAROLD WARNER,
Respondents,

ON WRIT OF CERTIORARI TO
THE UNITED STATES COURT
OF APPEALS FOR THE FIRST CIRCUIT

PETITIONERS' REPLY BRIEF

Stephen Schultz, Esq.
Massachusetts Department of
the Attorney General
One Ashburton Place
Boston, MA 02108
Tel.: (617) 727-4538

TABLE OF CONTENTS

STATEMENT OF THE CASE. . . . . .

ARGUMENT . . . . . .

I. THERE IS NO STATE LAW DISPOSITIVE OF THE ISSUES IN THIS CASE OR WHICH FURTHERS PLAINTIFFS' ARGUMENT THAT INVOLUNTARY PATIENTS HAVE A RIGHT TO REFUSE TREATMENT WITH ANTIPSYCHOTIC MEDICATION . . . . . .

A. The Massachusetts Case of In The Matter of Guardianship of Richard Roe, III, Did Not Resolve Or Deal With Any Issues of State Law Dispositive of the Issues Before This Court . . . . . .

B. The Roe Case Should Not Even Influence the Court's Decision in This Case . . . . . .

C. Massachusetts Statutes and Regulations and Admission Procedures at Boston State Hospital Do Not Indicate that Patients Have A Right to Refuse Treatment With Antipsychotic Medication . . . . . .

II. PLAINTIFFS' BRIEF SERIOUSLY MISSTATES DEFENDANTS' POSITION ON A NUMBER OF OCCASIONS . . . . . .

III. ALL THREE PETITIONERS VIGOROUSLY SUPPORT THE APPEAL OF THIS CASE. . .

IV. THE NAMED PLAINTIFFS WERE NOT SUBJECT TO ANY OF THE ABUSES CLAIMED IN PLAINTIFFS' BRIEF. . . . . .

V. THIS COURT SHOULD LIMIT ITS CONSIDERATION OF DISPUTABLE FACTS TO THE FACTS CONTAINED IN THE RECORD BELOW. . . . . .

VI. MEDICATION DECISIONS WERE MADE BY TRAINED PHYSICIANS AND WERE SUBJECT TO REGULAR REVIEW . . . . . .

CONCLUSION . . . . . .

Cases

Brown v. Richardson, 395 F.Supp. 185 (W.D. Pa. 1975) 16

Davis v. Hubbard, 506 F.Supp. 915 (N.D. Ohio 1980). 33,34

Dorchy v. Kansas, 272 U.S. 306 (1926) .32,36

Feeney v. Commonwealth, 373 Mass. 359, 366 N.E.2d 1262 (1977) 21

Greenholz v. Inmates of Nebraska Penal & Correctional Complex, 422 U.S. 1 (1979) 7

Guardianship of Richard Roe, III, In the Matter of, Mass. Adv. Sh. 981, 421 N.E.2d 40 (1981). 2,3,4,5

Ingraham v. Wright, 430 U.S. 651 (1977) . .5

Lawn v. United States, 355 U.S. 311 (1958). 32,35

McLellan v. Carland, 217 U.S. 268 (1910). 32

National Railroad Passengers Corp v. National Association of Railroad Passengers, 414 U.S. 453 (1974) 15

Rennie v. Klein, 653 F.2d 836 (3d Cir. 1981) 37

Rosen v. Lawson-Hemphill, 549 F.2d 205 (1st Cir. 1976) 32

Superintendent Belchertown State Schools v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1978) 9

Udall v. Oelschlaeger, 309 F.2d 974 (D.C. Cir. 1968). 16

Vitele v. Jones, 445 U.S. 480 (1980). . . .6

Wolff v. McDonald, 418 U.S. 539 (1974). . .7

Woodbridge v. Worcester State Hospital, Mass. Adv. Sh. 1581 (1981). . 12

Statutes

M.G.L. c. 123, §23. 14

M.G.L. c. 123, §25. 12

Regulations

D.M.H. Reg. §221.02 12

Articles

Brooks, A., "The Constitutional Right to Refuse Antipsychotic Medications", 8 Bull. Am. Acad. Psych. & L. 179 (1980).36

Mills, M., "Letter to the Editor", 9 Medicolegal News 2 (June, 1981) 24

Mills, M., "The Right of Involuntary Patients to Refuse Pharmacotherapy: What Is Reasonable?", 8 Bull. of Am. Acad. Psychi. and Law 313 (1981). . . . 21

Schultz, S., Swartz, W., Applebaum, J. "Deciding Right to Die Cases Involving Incompetent Patients" Jones v. Saikewicz, Suffolk L. Rev. 936 (1977). 9

STATEMENT OF THE CASE

Petitioner adopts the Statement of the Case set forth in pp. 5-12 of Petitioner's principal brief.

ARGUMENT

I. THERE IS NO STATE LAW DISPOSITIVE OF THE ISSUES IN THIS CASE OR WHICH FURTHERS PLAINTIFFS' ARGUMENT THAT INVOLUNTARY PATIENTS HAVE A RIGHT TO REFUSE TREATMENT WITH ANTIPSYCHOTIC MEDICATION.

A. The Massachusetts Case Of In The Matter Of Guardianship of Richard Roe, III Did Not Resolve Or Deal With Any Issues Of State Law Dispositive Of The Issues Before This Court.

Plaintiffs argue in their Brief, as they did in their Motion to Dismiss the Writ as Inprovidently Granted, that the Massachusetts Supreme Judicial Court case of In the Matter of Guardianship of Richard Roe, III, Mass. Adv. Sh. 981, 421 N.E.2d 40 (1981), disposes of the issues in this case on independent state grounds. Defendants, in their Opposition to Plaintiffs-Respondents Motion to Dismiss Writ or in the Alternative Certify Questions to the Supreme Judicial Court of Massachusetts (hereinafter referred to as "Petitioner's

Opposition"), at pp.10-28, have shown that Roe did not resolve or deal with any issues of state law dispositive of the issues before the court in the case at hand.

B. The Roe Case Should Not Even Influence The Court's Decision In This Case.

In their Brief, plaintiffs ask this Court to rely to a considerable degree on the court's opinion in Roe even if this Court does not find Roe to be dispositive of the issues in this case. Plaintiffs apparently wish this Court to adopt Roe's findings of fact regarding (1) the intrusiveness and side-effects of antipsychotic drugs, Resp. Br. at pp.11-12, 88, (2) the effect of antipsychotic drugs on personality, id. at p.26, (3) the effectiveness of antipsychotic drugs, id. at p.32, and (4) the burdensomeness of guardianship procedures, id. at pp.102-104. As noted in "Petitioner's

Opposition" at pp.23-24, 24-26, n.2, all of the findings of fact in Roe were made without the benefit of any record supporting the court's findings. This Court is neither bound to accept the Massachusetts' courts findings of fact nor are the findings of fact in Roe deserving of deference. Id. Roe must be recognized for what it is: an ill-reasoned, insignificant case, decided without the benefit of a record in a factually moot situation disposing of issues unlikely ever to arise again (i.e. the record indicated that forced medication in the home setting is not medically recommended). Roe Trans. 6/19/80, pp.122-125.

Plaintiffs further argue that Roe, even if not dispositive of this case, creates on state common law grounds a liberty interest to refuse treatment entitled to due process protection under the Fourteenth Amendment.

See, also, the Amicus Brief for Barbara Jamison, et al., at pp.5-7. However, as noted in "Petitioner's Opposition", the Supreme Judicial Court's findings that persons of "unsound mind" have a right to refuse treatment is founded on that court's interpretation of constitutional law and not on any determination of state law. To the extent that the Supreme Judicial Court in Roe founded its opinion on the common law, it must be recognized that a determination of the common law is intimately intertwined with a determination of what liberty interests are protected under constitutonal due process. As this Court stated in Ingraham v. Wright, 430 U.S. 651, 671-672 (1977), the liberty preserved from deprivation without due process includes "the right generally to enjoy those privileges long recognized at common law as essential to the orderly

pursuit of happiness by free men." (Citations omitted.) (Emphasis added.) Thus, a determination that a liberty interest is recognized in the common law is identical to a determination that a liberty interest is protected by the due process clause of the Constitution; such a determination cannot create an independent "state" liberty interest, not subject to review of this Court. It would be incongruous to accept the argument that the courts of all fifty states could each make their own determination of what liberty interests were protected by the common law and therefore constitutional due process, and that these decisions regarding the scope of the United States Constitution would not be subject to review by the United States Supreme Court. Certainly, the situation in this case does not resemble the fact patterns in Vitele v.

Jones, 445 U.S. 480, 489-490 (1980), Greenholz v. Inmates of Nebraska Penal & Correctional Complex, 442 U.S. 1, 11-16 (1979), and Wolff v. McDonald, 418 U.S. 539, 557-558 (1974), where this Court found that state statutes and regulations created liberty interests deserving of procedural due process protection.

Finally, plaintiffs apparently claim that at a minimum Massachusetts law requires that the decision to force treatment can only be made by a court utilizing a substituted judgment test of what the patient would want if competent.[1/] Resp. Br. at pp.105-107.

1/ Plaintiffs argue further that in those cases in which patients go in and out of competency , the substituted judgment procedure should satisfy the doctors' concerns that they will constantly be required to go to court whenever the patient's condition improves or deteriorates. Resp. Br. at p.94, n.22. (footnote continued)

However, by definition, the substituted judgment test can only be applied to incompetent patients. If this Court were to determine that "competency" is irrelevant to the state's authority to medicate forcibly an involuntary patient, the supreme judicial court's rulings regarding substituted judgment hearings for "incompetent" patients would be equally irrelevant. Moreover, the supreme judicial

---

1/ (footnote continuation)
Plaintiffs argue that only one hearing is necessary to determine what the person, when competent, would do if incompetent. Id. It is difficult, if not impossible, to understand why the use of a substituted judgment test, rather than a "best interests" or any other test, would prevent the need under plaintiffs' scheme for a separate hearing to determine a patient's competency each and every time a patient goes in and out of competency. If one accepts, arguendo, plaintiffs' arguments, the patient when competent has the right to make his own determination of whether to accept or refuse mediciation and should not be bound by a court's judicial "guestimate", see infra, pp.9-10, Fn.2, as to what the patient would want if competent.

court's opinion that a substituted judgment test is necessary to make treatment decisions for incompetent patients is based on that court's interpretation of the requirements of the United States Constitution as developed and evolved from the common law. See Superintendent Belchertown State Schools v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1978). If, arguendo, this Court were to reach the issue, it should reject the supreme judicial court's ill-advised opinion that the Constitution and common law requires courts to make subjective substitute judgment decisions regarding essentially non-justiciable issues such an incompetent patient's "real" desires concerning the taking of medication. See Schultz, S., Swartz, W., Applebaum, J., "Deciding Right to Die Cases Involving Incompetent

Patients: Jones v. Saikewicz", Suffolk L. Rev. 936, 941-949 (1977).[2/]

2/ For example, plaintiffs apparently argue that this Court should not consider the pain and suffering which accompanies major mental illness, see Pet. Br. at p.137, but rather should leave to a judicial determination for each patient the extent that the patient, if competent, would wish to avoid the pain and suffering of mental illness. Such an argument indicates the impossibility of trying to apply in practice the substituted judgment test as proposed by plaintiffs. How can anyone who has never experienced severe mental illness judge the extent of the pain and suffering experienced by the mentally ill? How can anyone ever assume that a person, if competent, would wish to resume the pain and suffering which accompanied the person's incompetence? Courts are simply ill-suited for making such highly discretionary and personal decisions and historically, other than pursuant to recent ill-advised Massachusetts decisions erroneously defining the requirements of due process, have declined to do so. See Schultz, et al., supra, at pp.946-948. This Court must define the implications of commitment, and weigh the relative interests of all patients and the state in treating committed patients with antipsychotic medication. A legal scheme must not be created whereby the courts must make subjective decisions on a daily basis outside their expertise or anyone else's expertise.

C. Massachusetts Statutes and Regulations and Admission Procedures at Boston State Hospital Do Not Indicate that Patients Have A Right to Refuse Treatment With Antipsychotic Medication.

Plaintiffs argue that a number of Massachusetts statutes, regulations and procedures indicate that as a matter of state law plaintiffs have the right to refuse treatment with antipsychotic medication. Defendants have already discussed many of the state statutes and regulations on which plaintiffs rely. See Pet. Br. at pp.31-33, Fn. 9; "Petitioner's Opposition" at pp.23-25. In this Reply Brief, defendants shall discuss the remaining state law claims made by plaintiffs.

Plaintiffs argue that M.G.L. c.123 §§8 and 9(c) imply that commitment in Massachusetts is not for treatment. Resp. Br. at p.85. In fact, these statutes

simply provide that a person must be discharged when the person no longer meets all the criteria for commitment. The statutes do not discuss whether the power to treat is concommitent with the original decision to commit.[3/]

Plaintiffs wrongly assert that D.M.H. Reg. §221.02 declares "that involuntarily committed patients, unless adjudicated incompetent, should be treated as competent." Resp. Br. at p.70, n.10. In fact, D.M.H. Reg. §221.02 is derived from M.G.L. c.123 §25, which specifically limits

---

3/ The recent Massachusetts Supreme Judicial Court case of Woodbridge v. Worcester State Hospital, Mass. Adv. Sh. 1581 (1981), is instructive as to whether Chapter 123 of the Massachusetts General Laws creates a "right to refuse treatment". In Woodbridge, the court declared that "the tenor of G.L. c. 123 as it relates to patients' rights is one of aspiration and encouragement, rather than of the creation of a formal system of actionable guarantees." Mass. Adv. Sh. at 1585.

and defines those areas in which an involuntary patient shall be treated as competent unless adjudicated as incompetent.[4/]

4/ The lower courts in this case also failed to acknowledge the distinction made by the law that involuntary patients can be considered competent for some purposes, but not treatment purposes. The lower court stated in a footnote that defendants' position is incredible that although committed, a mental patient would be presumed competent to deed his home to his doctor but would be considered incompetent whether to follow that doctor's advice concerning the taking of medication. Cert. App. p.752, n.12. This position, in fact, is completely logical and consistent. A committing court has already decided to override the patient's objection to treatment and hospitalization; the committing court has made no decision to override any other decisions made by the patient. A person may be competent to handle his financial affairs, yet, be totally blind to his need for treatment for mental illness which is interfering with other aspects of his life. Furthermore, the purpose of commitment in Massachusetts is treatment; the purpose of commitment is not to take away from the patient his right to handle his outside affairs to the extent they can still be managed in the hospital.

Plaintiffs further argue that the Massachusetts law requiring a patient's consent for electroshock and psychosurgery indicates that committed patients in Massachusetts are not considered functionally incompetent to make rational treatment decisions regarding psychiatric treatment. Resp. Br. at pp.75-76; M.G.L. c.123 §23. M.G.L. c.123 §23 cannot be read as acknowledging the "functional competency" of committed patients; rather, the statute is a legislative statement that electroshock and psychosurgery are so intrusive that they should not be given without the approval of a second party (either the patient or his guardian). In fact, the significant aspect of M.G.L. c.123 §23 is that it singles out electroshock and psychosurgery as the only psychiatric treatments requiring a patient's consent and deliberately does not

include a requirement of patient consent for all psychiatric treatments or specifically for the use of antipsychotic medication. A traditional principle of statutory construction is that the express mention of specific matters in a statute excludes by implication other matters which are not mentioned. National Railroad Passengers Corp. v. National Association of Railroad Passengers, 414 U.S. 453, 458 (1974).

Plaintiffs also cite to a D.M.H. Civil Rights poster stating that patients have the right "to refuse treatment at any point." Resp. Br. at pp.73, n.11, 76; Jt.App. at pp.36-38. Plaintiffs omit that the poster specifically provides that the rights mentioned on the poster may be withheld for good cause. Jt.App. at p.37. Moreover, even if, arguendo, the poster did purport to give patients a right to refuse

treatment, the government cannot be estopped by an erroneous statement on a poster or past mistakes of its agents. Udall v. Oelschlaeger, 309 F.2d 974, 977 (D.C. Cir. 1968); Brown v. Richardson, 395 F.Supp. 185, 189, 191 (W.D. Pa. 1975).

Finally, plaintiffs rely on an Admission Packet provided all patients upon their admission which states that "no medical or surgical treatments including electroconvulsive treatment are given without the consent of the patient." Resp. Br. at p.73, n.11. Plaintiffs omit an earlier sentence of the Admission Packet which provides that "[a] course of treatment may include counselling, medications, electroconvulsive treatment, and treatment of any medical condition that the patient may be found to have". Jt.App., p.30. The singling out of electroconvulsive treatment in the sentence

cited by plaintiffs clearly indicates that courses of treatment such as counselling and medication do not require a patient's consent.

II. PLAINTIFFS' BRIEF SERIOUSLY MISTAKES DEFENDANTS' POSITION ON A NUMBER OF OCCASIONS.

Plaintiffs, throughout their Brief, have set up straw men to knock down, while avoiding the central issues in the case. Principally, plaintiffs base much of their argument on the assumption that a competency determination is relevant to the decision to treat an involuntary patient rather than discussing why a competency determination should be relevant or whether it is practical to require a competency decision to treat an involuntary patient.

In avoiding the central issues in the case, on a number of occasions plaintiffs seriously mistate defendants' position. For example, plaintiffs create and then

reject "the doctors' argument that the state has a constititutional duty to treat all involuntarily committed patients." Resp. Br. at p.86. In fact, defendants specifically note that they do not take any position as to whether patients have a constitutional right to treatment. Pet. Br. at pp.21-22, n.5. The issue in the case is whether attempting to treat involuntary patients over their objections is a legitimate objective of the state; the issue is not whether the State is so obligated to treat the involuntary patient.

Similarly, plaintiffs contend that "it is inaccurate for the State to argue that treatment is the historic objective of the parens patriae commitment power." Resp. Br. at pp.84-85. In fact, defendants never contended that treatment was the historic objective of commitment. Rather, defendants have noted tht only since the

introduction of antipsychotic medications in the 1950's have hospitals been able to treat effectively a large percentage of involuntary patients, and it is only since the 1950's that the states have been able to accept the very legitimate function of treating those patients now susceptible to treatment.

Plaintiffs argue that "defendant. . . stipulated that it is good practice to utilize less restrictive alternatives prior to forcibly medicating patients with antipsychotic drugs." Resp. Br. at p.123, n.29. In fact, defendants only stipulated that when a patient is beinq upset by environmental factors, a doctor should consider placing the patient in a quiet room or separating the patient from another patient before secluding the patient or administering chemical restraints. Jt.App. pp.184-185,284. Moreover, defendants have

denied throughout this litigation that antipsychotic medication given in therapeutic doses acts as a chemical restraint. Jt.App. p.273 (K-221-229).[5/]

III. ALL THREE PETITIONERS VIGOROUSLY SUPPORT THE APPEAL OF THIS CASE.

Plaintiffs argue that the petitioner Mark Mills agrees with many of the factual findings and legal holdings of the lower courts in this case. Resp. Br. at pp.142-146. Plaintiffs in support of this

---

5/ Similarly, plaintiffs misstate the American Psychiatric Association's position when plaintiffs claim that "the APA maintains that the state's police power can be satisfied without the use of anti-psychotic drugs". Resp. Br. at p.121,n.28. In fact, the APA notes the impracticability of artificially distinguishing between the state's parens patriae and police powers, as both justify treatment of the committted patient. APA Br. at p.11. See, also, the Brief of the American Psychological Association at pp.23-25, et al., admitting that the state has a legitimate police power interest in improving the health of individuals for the benefit of society.

contention cite to an article authored by petitioner Mills. Mills, M., "The Right of Involuntary Patients to Refuse Pharmacotherapy: What Is Reasonable?", 8 Bull. of Am. Acad. Psychi. and Law 313 (1981).

Mark Mills is not an original defendant in this case. He was substituted for Commissioner Okin only after certiorari was granted in this case. The other two petitioners, Michael Gill and William Malamud, who have been involved in this case from the outset, have vigorously supported the defendants' position throughout the litigation. Cf. Feeney v. Commonwealth, 373 Mass 359, 366, 366 N.E.2d 1262, 1267 (1977) (when in the judgment of the Attorney General, an appeal would further the interests of the Commonwealth and the public he represents, the Attorney General may prosecute an appeal to the Supreme Court of the United States even

over the expressed objections of the State officers he represents.)

Mark Mills wrote the article cited by plaintiffs before he became Commissioner of the Department of Mental Health. After becoming Commissioner and having had the opportunity to study the record in this case regarding the impact at Boston State Hospital of allowing involuntary patients to refuse treatment, Mills now firmly believes that in Massachusetts, where commitment is based only on serious mental illness and dangerousness or the inability to care for oneself, the forcible administration of antipsychotic medication must be allowed on an involuntary patient, regardless of whether or not the patient is "legally" competent. Mills still believes that the rationality of the reasons offered by a patient refusing medication should be an important factor taken into account by

the treating physician in his decision whether to force medication. He also recognizes, however, that an involuntary patient's competency (i.e., ability to understand the benefits and risks of medication) must not be the sole factor determining the state's power to override the patient's refusal of medication. Rather, Mills now believes that the same findings which permit the state to commit a patient regardless of his competency must also justify the state to treat the patient regardless of his competency. As Mills wrote after his appointment as Commissioner,

> Upon reconsidering my article "The Continuing Clinicolegal Conundrum of the Boston State Hospital Case", 9 Medicolegal News, 9 (1981), in my new role as Commissioner of Mental Health for Massachusetts, I am increasingly troubled by the Court of Appeals opinion in Rogers v. Okin. What distresses me is that the court engages in policy-making without an adequate constitutional foundation, and that the judicially-promulgated policy is too rigid in its imposition

on clinical decision-makers. I believe it should not stand and have thus welcomed the Commonwealth's appeal to the Supreme Court, which has granted certiorari.

9 Medicolegal News 2 (June, 1981).

IV. THE NAMED PLAINTIFFS WERE NOT SUBJECT TO ANY OF THE ABUSES CLAIMED IN PLAINTIFFS' BRIEF.

Plaintiffs cite to the case histories of three of the named plaintiffs in an attempt to show past abuses by the defendants. Specifically, plaintiffs claim that Rubie Rogers, Betty Bybel and Willie Wadsworth were all somehow mistreated in the past.6/

Plaintiffs cite to the case of Ruby Rogers to support their contention that before the temporary restraining order in

---

6/ In reviewing these case histories, the starting point, of course, is the lower court's findings that the defendants acted in good faith in accordance with accepted standards of medical practice. See, Pet. Br. at pp.100-101.

this case, the doctors did not listen to the complaints of patients about the pain and discomfort caused by their medication. Rep. Br. at p.10, n.1. Rubie Rogers' record indicates, however, that physicians before the temporary restraining order evaluated Rubie Rogers' complaints regarding her medication on numerous occasions. Jt. App., pp.357-358 (G-100-105). Moreover, the record indicates that Rogers had numerous somatic delusions regarding side-effects from medication, as evidenced by the fact that she complained of side effects even when she was not receiving the medication. Jt. App., pp.361-363 (G-151-164). The fact that the doctors changed Rogers' medication to moban after the temporary restraining order is indicative only of the fact that moban was a new drug which had just recently become available and that Rogers

had built up an antipathy to her prior drug of haldol, regardless of its side effects. Tr. 58 at 11, 96.

Plaintiffs cite to the case of Betty Bybel to support their position that defendants used antipsychotic medication to control and subdue what the staff believed to be "bizarre" or "morally offensive" behavior. Resp. Br. at p.60, n.7. Plaintiffs assert that Bybel was "oversedated" in December, 1973 and January, 1974, because she was a "ringleader", complaining about the competency of staff. Id.7/

7/ Plaintiffs rely principally on the testimony of Elizabeth Franceen, a mental health worker, in support of this assertion. Franceen's testimony, like the testimony of all plaintiffs' lay witnesses, suffers from the witness' lack of sophistication and knowledge regarding severe mental illness. See, Def's Proposed Findings of Fact at pp.342-349 First Cir. App. at p.1916-1923
(footnote continued)

The record indicates, however, that during the entire time of her

---

7/ (footnote continuation) (J-26-44) setting forth the tremendous difference in the credentials of defendants' and plaintiffs' lay witnesses. See, also, Def's Proposed Findings of Fact at pp.329-342, First Cir. App. at pp.1882-1916 (J-1-26) showing the large disparity between the credentials of defendants' and plaintiffs' expert witnesses, and Def's Proposed Findings of Fact at pp.17-21, First Cir. App. at pp.871-880 (B-8-21) setting forth the expert credentials of the defendants in the case. Franceen never worked on the ward of a psychiatric hospital before or after her employment at the Austin Unit. Def's Proposed Findings of Fact at p.348, First Cir. App. at p.1924 (J-42). She worked at the Austin Unit for only six months. It is of the utmost import that in the thirty-nine days plaintiffs took to present their case, they did not call a single professional who had worked at the hospitals during the time in question or a single person directly responsible (as doctor, nurse, team leader or administrator) for any of the plaintiffs in this case. Not only were plaintiffs apparently unable to find a single doctor (psychiatrist or psychologist) who agreed with their view of the facts, they also failed to call a single registered nurse, licensed nurse, social worker or other trained professional to testify.

hospitalization, and specifically during the period of December, 1973 to January, 1974, Bybel's illness created a situation that posed a serious threat of personal injury to herself or others. Jt.App. at pp.318-320 (D-220-222); see, also, Jt.App. pp.306-313 (D-1-58). In fact, Dr. Gill testified that Bybel was one of the ten most disturbed patients he had treated during his eighteen years of work on acute psychiatric wards, while Dr. Myerson, who has studied violent female psychiatric patients, testified that Bybel had one of the most serious manic disorders he had seen or read about in his thirty-five year career. Defs' Proposed Findings of Fact at pp.59, 334, First Cir. App. at pp.1006, 1887 (D-75-76, J-13). The record further indicates that Betty Bybel was not a ringleader, Jt.App. at pp.312-313 (D-40-58), Bybel's illness prevented her

from being "assertive", Id., p.314 (D-184-186), and that on the one occasion that antipsychotic medication did make Bybel lethargic in January, 1974, her medication dosage was promptly cut back and her lethargy decreased. Id. pp.315-317 (D-191-198). The fact that Bybel did not seem dangerous to the untrained eye of Franceen is of little significance, given that manic patients such as Bybel can appear externally calm to the untrained attendant, yet be in a state of inner turmoil creating a serious threat of danger to the patient and others. Defendants' Proposed Findings of Fact at p.353, First Cir. App. at p.190 (J-65-68).

Finally, plaintiffs cite to the case of Willie Wadsworth in support of their position that doctors' loyalty to patients at Boston's State Hospital was reduced by staff pressures to maintain "peace and

tranquility" on the ward. Resp.Br. at pp.128-129, n.31. Plaintiffs seem to argue that the defendant, Dr. Goodman, kept Wadsworth in seclusion in part because of staff pressure.[8/] Id. Dr. Goodman

---

8/ Plaintiffs further argue that the defendants in Wadsworth's and other cases violated the procedural and substantive standards for using seclusion. Resp.Br. at pp.131, 153. Thus, plaintiffs argue that defendants are likely to abuse any right they are given to make their own decisions regarding the use of forcible medication. Id. Plaintiffs somehow seek support for their position in the fact that defendants did not appeal the trial court's findings that seclusion was misused. Despite the fact that the trial court's findings of wrongful use of seclusion were clearly erroneous (see Defendants'-Appellees' Brief in the First Circuit at pp.23-26, 31-32, to-67, 70-73, 80-83, 91-94, 96-97), defendants did not appeal these findings solely because the trial court's order merely repeated state statutory law and defendants wished to avoid unnecessary litigation of no consequence. Moreover, the First Circuit implicitly rejected the trial court's findings that seclusion was used for improper reasons. Cert. App., pp.33a-34a. The trial court found that defendants never used seclusion for punishment, but only used seclusion (1) to prevent violence, and (2) for therapeutic (footnote continued)

testified, however, as to the real reason he kept Willie Wadsworth in seclusion. He testified that when he began his residency the staff did feel strongly that Wadsworth should be in seclusion. Tr. 24 at pp. 58-64, 82-84. He also testified, however, that rather than simply acceding to staff pressure, he made his own independent judgment that Wadsworth needed seclusion. Id. He noted that his judgment was supported by the fact that Wadsworth upon meeting Dr. Goodman threw coffee in his face. Id.

8/ (footnote continuation) purposes. Cert. App., pp. 139a, 158a. The First Circuit found in upholding the denial of plaintiff's damage claims, that "the seclusion statute does not explicitly prohibit the use of seclusion for therapeutic purposes, and therefore, given the difficulty and complexity of the task defendants faced, it may not have been unreasonable to regard this portion of the statute as totally inapplicable to efforts aimed at curing patients." Id. at p.33a-34a: Brief for the Defendants-Appellees to the First Circuit, at pp.60-67, 70-73, 80-83, 91-94, 96-97.

V. THIS COURT SHOULD LIMIT ITS CONSIDERATION OF DISPUTABLE FACTS TO THE FACTS CONTAINED IN THE RECORD BELOW.

Plaintiffs, and amicus supporting plaintiffs, have sought to call this Court's attention to a number of disputable facts outside of the record in this case. This Court should not consider such facts in reaching its decision. Lawn v. United States, 355 U.S. 311, 354 (1958); Dorchy v. Kansas, 272 U.S. 306, 310-311 (1926); McClellan v. Carland, 217 U.S. 268, 282-283 (1910); Rosen v. Lawson-Hemphill, 549 F.2d 205 (1st Cir. 1976).

The amicus brief of the Advocates for Basic Legal Equality contains the most flagrant attempt to call to the Court's attention facts outside of the record. This Court should disregard the entire brief. Amicus took the deposition of the clinical director of an Ohio hospital

involved in the federal case of Davis v. Hubbard, 506 F.Supp. 915 (N.D. Ohio 1980).[9/] The deposition was taken without notice to counsel in the Mills case and outside the procedures of the Mills case. See Appendix to Amicus Brief at p.2. Amicus' entire brief is founded on

---

9/ In addition to the attempt by the Davis plaintiffs to introduce an outside transcript into the record of this case, plaintiffs in this case have asked this Court to consider the factual findings of the district court in Davis regarding the actual effects of recognizing a right to refuse treatment. Resp.Br. at p.140. Even if, arguendo, this Court were to consider the Davis findings, the district court in Davis found no more than that there was no testimony in that case that recognizing a right to refuse treatment has had adverse effects on the operation of institutions. 506 F.Supp. at 937, n.31. From this finding alone, which is stated in negative terms, one cannot conclude whether there was any testimony one way or the other regarding the actual effects of recognizing a right to refuse treatment on the operation of institutions.

the testimony taken at this deposition.[10/] This is the precise situation found in the

---

10/ Even if this Court, arguendo, were to consider the facts set forth in the Advocates for Basic Legal Equality Amicus Brief, those facts offer little guidance to this Court for deciding this case, and, if anything, support the contentions of the defendants in this case. Amicus relate the history of Lima State Hospital which pursuant to a court order has held hearings before forcibly medicating patients. The hearings are apparently held by the clinical director on the same day a patient refuses his medication. Amicus Br. at p.8. Lawyers are not allowed at the hearings. App. to Amicus Br. at p.26. Amicus does not indicate what criteria the clinical director considers in whether or not to override a patient's refusal of medication. It is clear, however, that the clinical director has not been considering whether or not the patient is competent. This is evidenced by the fact that the district court in Davis found that 85% of the patients at Lima State Hospital are capable of rationally deciding whether to consent to the use of antipsychotic drugs, 506 F.Supp. at 927; yet, the clinical director has overriden the patients' refusal of medication 75% of the time. Amicus Br. at pp.6-7. Moreover, the clinical director noted that many of the 16 patients who were allowed to refuse medication eventually took their medication: i.e., (1) some of the patients (footnote continued)

Lawn case where this Court refused to consider the transcript of a hearing not

---

10/ (footnote continuation) were eventually persuaded to take the medication voluntarily, (2) some of the patients objected only to the brand of the medication being offered, (3) some of the patients objected only to the dosage prescribed, (4) some patients off the medication had a return of symptoms which resulted in the need for forcible medication, and (5) in one case, the clinical director changed his mind and decided the patient did need his medication. App. to Amicus Br. at pp.27-28. Thus, the Amicus transcript seems to indicate that at Lima State Hospital a review procedure has been established involving only the clinical director, the results of which are that almost every patient refusing his medication has nevertheless been given medication. The clinical director apparently now supports these procedures. Id. at 17-18. The procedures do not sound particularly different than those followed at Boston State Hospital before the temporary restraining order, where medication orders were regularly reviewed by physicians including the medical director who (1) attended rounds, (2) attended staff reviews of medication and (3) had the authority to override decisions to forcibly medicate. See Pet. Br. at pp.69-71; Pet. Reply Br., infra, at pp. 36-39. Similarly, at Boston State Hospital, before the temporary restraining order refusals of medication would be (footnote continued)

included in the certified record of the case. 355 U.S. at 354. Similarly, this Court in Dorchy excluded the record of another case wholly independent of the case before the Court. 272 U.S. at 310-311.

For the same reasons cited above, this Court should also disregard the attempt in the Brief of the Amicus American Psychological Association, et al., at pp.26-27 to have this Court consider a study conducted by Brooks[11/] discussing

---

10/ (footnote continuation) honored when consistent with the standards of acceptable medical practice, as the doctors preferred to act with the cooperation of the patient if possible. Jt. App., pp.189-196, 196-197 (J-86, 93, 95-96). There are apparently only two major differences between Lima State Hospital and Boston State Hospital: (1) at Lima State Hospital there was a history of use of medication for convenience and punishment, 506 F.Supp. at 926, which did not exist at Boston State Hospital, and (2) Lima State Hospital did not apparently begin regular review of their medication orders until after court intervention.

11/ Brooks, "The Constitutional Right to Refuse Antipschotic Medications", 8 Bull. Am. Acad. Pych. & L. 179 (1980).

the New Jersey experience living under the court order issued in the case of Rennie v. Klein, 653 F.2d 836 (3d Cir. 1981) (en banc).

Finally, this Court should not consider plaintiffs' contention, which was not raised below, that evidence outside the record of this case shows that mental patients are no more dangerous than the general population.[12/] Resp. Br. at p.113, 426.

12/ In fact, the evidence to which plaintiffs cite shows only that mentally ill persons outside hospitals may be no more dangerous that the general population. The evidence certainly does not indicate that mental patients already found beyond a reasonable doubt to be dangerous or unable to care for themselves because their judgment is grossly impaired are not more dangerous than the general population.

VI. MEDICATION DECISIONS WERE MADE BY TRAINED PHYSICIANS AND WERE SUBJECT TO REGULAR REVIEW.

Plaintiffs argue that residents, who had barely graduated medical school, were immediately provided total responsibility for medicating patients. Resp. Br. at pp.129-130, n.32. Plaintiffs further argue that supervision of residents was only marginally adequate.[13/]

Defendants accept that residents have less training than non-resident doctors. However, all residents had participated in clinical programs while in medical school. Moreover, the residency at Boston State Hospital was the second, not the first,

---

13/ Specifically, plaintiffs argue that Dr. Kantar supervised residents for only an hour to an hour and one-half per week. Id. The one and one-half hours only represents Dr. Kantar's time spent on formal supervision of each resident and not the many hours he informally met with residents, attended team meetings, attended ward meetings, etc. Tr. 48 at 5-7.

placement in the residency program. During the first year of the residency, all residents, although working elsewhere, were on call evenings and weekends at Boston State Hospital. See Tr. 43 at pp.3-9, describing the residency program. To characterize the Boston State residents as barely out of medical school misconceives the intensive clinical training residents had already experienced by the second year of their residency program.

Moreover, residents were hardly provided total responsibility for medicating patients. Patients' medications at the Austin Unit were reviewed regularly on an ongoing basis by the entire staff in rounds, team meetings, staff meetings, and on an impromptu basis whenever an issue surrounding a patient's medication arose. Jt.App. at p.270 (K-196). Staff at the

Austin Unit met regularly to discuss patients' treatment: at rounds five days a week, at team meetings twice weekly, at staff meetings, and at privilege meetings with staff and patients once a week. Id. (K-198). Patients at the Austin Unit met with staff, including the ward physician, once a week in order to discuss the eficacy and side effects of each patient's medication. Id. (K-199). Dr. Gill, the Unit's director, was present at daily rounds. Tr. 63 at pp.132-136. There was a weekly executive committee meeting attended by heads of the various disciplines. Id. There was a weekly clinical case conference chaired by visiting staff. Id. There was a supervision seminar to discuss supervisory techniques. Id.

It was the policy and practice at the May Unit that patients' medications were

reviewed regularly by their physicians at the weekly administrative meetings and the team meetings on each of the wards. Jt.App. at p.271 (K-202). Team meetings of staff and patients were held on each ward of the May Unit twice a week, and the details of the side effects of drugs were reviewed at these meetings. Id. (K-203). The in-patient director met regularly with residents as a group each week. Tr. 60 at 64-65. In addition, weekly teaching conferences were held with residents, as were clinical rounds and weekly May Unit meetings. Id.

CONCLUSION

For the reasons stated in this Reply Brief as well as in Petitioner's Brief on the Merits, this Court should declare that involuntarily committed mental patients do not have a right to refuse treatment with antipsychotic medication.

By Petitioner's Attorney,

FRANCIS X. BELLOTTI
ATTORNEY GENERAL

Stephen Schultz
Administrative and Legal
Counsel to the
Attorney General
One Ashburton Place
Room 2001
Boston, MA 02108
Tel.: (617) 727-4538

Dated: 12/31/81